

**Child Fatality Review #08-55**  
**Region 5**  
**Kitsap County**

This two-year-old African American female died from complications related to a birth defect of her heart.

**Case Overview**

On October 3, 2008, this child died from sudden cardiac arrest while at a Kitsap County hospital. The Kitsap County Coroner reported the child was not in good health. The child was born with a birth defect characterized by an undeveloped left side of the heart. This defect was not correctable. This child had a prior stroke as well as multiple surgeries and medical procedures. Prior to the child's death, heart surgery was postponed due to the child's weakened health. The County Coroner indicated there was no plan for further investigation of the circumstances of death. The Kitsap County Community Child Death Review Team declined to review the incident given indications of a clear medical cause of death.

**Referral History**

On August 4, 2006, an anonymous report was made to Child Protective Services (CPS) intake alleging domestic violence (DV) between the parents of the deceased child. The mother allegedly threw objects at her husband; he tried to protect the children. This referral was screened out for investigation.

On September 5, 2006, a report was made to CPS intake alleging the deceased child's two-year-old sister was molested by a non-related teenager. He is a registered sex offender. This information was forwarded to the Bremerton Police Department. This referral was screened out for investigation.

On November 30, 2006, a social worker reported to CPS intake that the uncle of the deceased child was visiting the family home. He is a registered sex offender and was not to be in the home with children present. This referral was screened out for investigation.

On February 12, 2007, a mental health professional reported to CPS intake the mother of the deceased child said she had photographic evidence that the children's father was harming her two daughters. The referrer said the mother has a history of making false allegations about others harming her children. This referral was screened out for investigation.

On March 7, 2007, a home health care worker reported to CPS intake the then seven-week-old sister of the deceased child had a medical condition that limited her ability to gain weight. The child's mother did not show for an appointment to bring this child to a doctor. The health care worker reported she is the main caregiver during the day and the children are ignored at night. All three of the children in the home have serious medical conditions or developmental delays. This referral was screened out for investigation.

On March 8, 2007, a medical professional reported to CPS intake the then seven-week-old sister of the deceased child had a sinus infection and her parents did not give her the proper dosage of medications to treat this condition. This infant had poor weight gain. This referral was screened in for investigation for negligent treatment or maltreatment and closed with an inconclusive finding. Children's Administration staff continued to work with the family after the initial CPS investigation. The family was already working with the Division of Developmental Disabilities, public health, and an Infant Toddler and Early Learning Program. The family accepted additional services including day care, parenting class, NCAST (Nursing Child Assessment Satellite Training) assessment, nutritionist, and home-based service funds. During this time the deceased child's heart situation deteriorated according to the heart specialist.

On March 13, 2007, a report was made to CPS intake alleging the deceased child's father spanked her then two-year-old sister leaving brief marks. The mother told the referrer she had proof. This referral was screened out for investigation. The case remained open for services.

On March 23, 2007, a report was made to CPS intake alleging the parents of the deceased child and her two sisters shake and yell at them. The mother carried the 12-month-old sister, but did not support the baby's head. Both the mother and father pick up the children by the arm, and, they yell at the children threatening to beat their butts. They spanked the children and flicked them on the face. The referrer also reports the mother allowed her brother, a registered sex offender, to visit the home. This referral was screened in as Low Risk. The case remained open for services.

On August 29, 2007, a Head Start worker reported to CPS intake the seven-month-old sister of the deceased child was not getting nutritionally sufficient and appropriate food. This referral was screened in for investigation for negligent treatment or maltreatment and closed with an inconclusive finding. The case remained opened to provide Intensive Family Preservation Services (IFPS) to the family.

On June 11, 2008, a report was made to CPS intake alleging the deceased child's mother was pregnant. This referral was screened out for investigation.

On September 22, 2008, a report was made to CPS intake that an in-home care provider had spanked one of the children. No marks or bruises were left on the child. This referral was screened out as a Third Party referral.

On October 3, 2008, hospital staff reported to CPS intake that the deceased child died while hospitalized. She was born with a congenital heart defect and her death was determined to be natural. This referral was screened out for investigation.

### **Issues and Recommendations**

**Issue:** While the entire family history of involvement with CA was reviewed in summary, primary and detailed focus during the review was on the last 14 months prior

to the child's demise from a medical cause of death (congenital heart defect). No significant practice, policy, or system issues were identified. Several minor errors and practice deficits were noted during the child fatality review. None appeared to have any obvious impact with regard to the circumstances of the child death. These are included below as documentation of the discussions occurring during the child fatality review.

**Recommendation:** None.

**Issue:** A CPS referral made in late August 2007 identified only the mother as a subject of allegations of negligent treatment. However, the referent stated concerns of possible neglect by both parents to the deceased child's seven-month-old sister and thus the father should have also been identified as an alleged subject.

**Recommendation:** None.

**Actions Taken:** Region 5 Intake Supervisors and Intake Area Administrator were provided feedback regarding the failure to identify all subjects in the August 2007 intake.

**Issue:** CPS Investigation: The most recent CPS investigation, initiated 14 months prior to the fatality incident, involved a younger sibling of the deceased. An unannounced home visit and face-to-face contact with the alleged victim and contact with the parents were conducted in a timely manner. The family was receiving Division of Children and Family Services Family Voluntary Services (FVS) at the time of the referral, and there is documentation that the CPS worker collaborated with the assigned FVS worker for the case and most of the collateral contacts were made by the FVS worker. The CPS worker did not contact the referent (mandated reporter). Best practice would suggest such contact be made routinely, but especially when there is conflicting information gathered from other professional sources. The CPS case assignment remained inactive from mid-October 2007 until mid-February 2008 (four months) at which time there were no CPS investigative activities. Notification of finding was sent to the alleged subject at that time, and this is well after prescribed timeframes for completion of the CPS investigation and notification of findings to an alleged subject. Additionally, some documentation by the CPS investigator was not input into the CA data base until 3-4 months after the actual activity took place, in violation of documentation policy. The Investigative Assessment as completed by the CPS worker indicates a finding of "Inconclusive" as to the allegation of negligent treatment by the mother. However, the worker stated in at least two key narratives that the allegation was clearly "Unfounded." The worker stated during the review that he clearly remembers the allegation being unfounded, but he may have inadvertently marked the wrong check box when completing the findings section of the Investigative Assessment.

**Recommendation:** None.

**Actions Taken:** The social worker who conducted the August 2007 CPS investigation, the CPS supervisor, and the current CPS Area Manager participated in the review and received feedback regarding delayed documentation, excessive inactivity, and delayed

CPS case closure. The deficits were acknowledged as having occurred but were presented as not being reflective of a pattern of practice within the Bremerton DCFS office.

**Issue:** Family Voluntary Services: During the nine months the FVS case was active (May 2007-February 2008), efforts to meet the health, safety, and welfare needs of the children in the home appear to be exceptional in terms of service provision and risk reduction. However, the worker did not obtain signed service plans nor conduct any Comprehensive Family Assessments as required by policy for provision of FVS. Numerous and continuous contacts with professionals involved with the family were well documented. While such contacts with individual providers merits recognition as good practice, a more collaborative process such as conducting a multi-disciplinary team staffing may have been more productive in terms of developing a family plan at case closure.

**Recommendation:** None.